

City of San Jose  
Active Employees and Early Retirees  
Group# H12020, H12021  
Custom Access+ HMO® 25  
Benefit Summary (For groups of 300 and above)  
(Uniform Health Plan Benefits and Coverage Matrix)

THIS MATRIX IS INTENDED TO BE USED TO  
HELP YOU COMPARE COVERAGE BENEFITS  
AND IS A SUMMARY ONLY. THE *EVIDENCE  
OF COVERAGE AND PLAN CONTRACT*  
SHOULD BE CONSULTED FOR A DETAILED  
DESCRIPTION OF COVERAGE BENEFITS  
AND LIMITATIONS.

## Blue Shield of California

Highlights: A description of the prescription drug coverage  
is provided separately.

Effective January 1, 2011

**Calendar year medical deductible**

None

**Calendar year copayment maximum<sup>1</sup>** (For many covered services)

\$1,000 per individual/  
\$2,000 per family

### LIFETIME BENEFIT MAXIMUM

None

### Covered Services

### Member Copayment

#### PROFESSIONAL SERVICES

##### Professional (physician) benefits

- Physician and specialist office visits

\$25 per visit

Note: A woman may self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services.

- Outpatient X-ray, pathology and laboratory

No charge

##### Allergy testing and treatment benefits

- Office visits (includes visits for allergy serum injections)

\$25 per visit

##### Access+ Specialist<sup>SM</sup> benefits (Self-referred office visits and consultations only)<sup>1, 2</sup>

- Office visit, examination or other consultation

\$40 per visit

##### Preventive health benefits

- Routine physical examination office visit** (according to age schedule) Including the physical examination office visit, gynecological office visit, routine eye/ear screening for members through age 18 and pediatric and adult immunizations and the immunization agent. Note: A woman may self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services.

No charge

- Immunizations (according to age schedule)

No charge

#### OUTPATIENT SERVICES

##### Hospital benefits (facility services)

- Outpatient surgery performed in an ambulatory surgery center<sup>3</sup>
- Outpatient surgery in a hospital
- Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation benefits")

\$50 per surgery  
\$100 per surgery  
No charge

#### HOSPITALIZATION SERVICES

##### Hospital benefits (facility services)

- Inpatient physician services
- Inpatient non-emergency facility services (semi-private room and board, medically necessary services and supplies)
- Inpatient medically necessary skilled nursing services including subacute care<sup>4</sup>

No charge  
\$100 per admission  
No charge

#### EMERGENCY HEALTH COVERAGE

- Emergency room services not resulting in admission (Copayment does not apply if the member is directly admitted to the hospital for inpatient services)
- Emergency room physician services

\$100 per visit  
No charge

#### AMBULANCE SERVICES

- Emergency or authorized transport

\$50

#### PRESCRIPTION DRUG COVERAGE

##### Outpatient prescription drug benefits<sup>1</sup>

A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug summary that goes with this benefit summary, please contact your benefits administrator or call Member Services.

#### PROSTHETICS/ORTHOTICS

- Prosthetic equipment and devices (Separate office visit copay may apply)
- Orthotic equipment and devices (Separate office visit copay may apply)

No charge  
No charge

<b>DURABLE MEDICAL EQUIPMENT</b>	
• Durable medical equipment (of allowed charges) <sup>1</sup>	No charge
<b>MENTAL HEALTH SERVICES (PSYCHIATRIC) <sup>5</sup></b>	
• Inpatient hospital services	\$100 per admission
• Outpatient mental health services	\$25 per visit
<b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE) <sup>7</sup></b>	
<b>Please see footnote 6</b>	
• Chemical dependency and substance abuse services	Not covered
<b>HOME HEALTH SERVICES</b>	
• Home health care agency services (Up to 100 visits per calendar year)	\$25 per visit
• Medical supplies and laboratory services (For home self-administered injectable medications, see "Prescription Drug Coverage.")	No charge
<b>OTHER</b>	
<b>Hospice program benefits</b>	
• Routine home care	No charge
• Inpatient respite care	No charge
• 24- hour continuous home care	No charge
• General inpatient care	No charge
<b>Pregnancy and maternity care benefits</b>	
• Prenatal and postnatal physician office visits (For inpatient hospital services, see "Hospitalization Services.")	No charge
<b>Family planning and infertility benefits</b>	
• Counseling and consulting	No charge
• Infertility services (of allowed charges) (Diagnosis and treatment of causes of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)	50%
• Tubal ligation <sup>8,9</sup>	\$100 per surgery
• Elective abortion <sup>9</sup>	\$100 per surgery
• Vasectomy <sup>9</sup>	\$75 per surgery
<b>Rehabilitation benefits (physical, occupational and respiratory therapy)</b>	
• Office location (Copayment applies to all place of services, including professional and facility settings)	\$25 per visit
<b>Speech therapy benefits</b>	
• Office location	\$25 per visit
<b>Diabetes care benefits</b>	
• Devices, equipment and non-testing supplies (of allowed charges) (For testing supplies, see "Outpatient Prescription Drug Coverage Summary.")	No charge
• Diabetes self-management training	\$25 per visit
<b>Hearing aid services</b>	
• Audiological examination	No charge
• Hearing aid and ancillary equipment (Plan payment up to \$1,000 maximum per member every 36 months)	No charge
<b>Urgent care benefits (BlueCard® Program)</b>	
• Urgent services outside your personal physician service area	\$50 per visit
<b>Optional benefits <sup>1</sup></b>	Optional dental, vision, infertility, substance abuse, chiropractic or chiropractic and acupuncture benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

1 Copayments marked with a (1) do not accrue to calendar-year copayment maximum. Copayments and charges for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. Please refer to the Evidence of Coverage and the plan contract for exact terms and conditions of coverage.

2 To use this option, members must select a personal physician who is affiliated with a medical group or IPA that is an Access+ provider group, which offers the Access+ Specialist feature. Members should then select a specialist within that medical group or IPA. Access+ Specialist visits for mental health services must be provided by a MHSA network participating provider.

3 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.

4 Skilled nursing services are limited to 100 preauthorized days during a calendar-year except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on skilled nursing services is a combined maximum between SNF in a hospital unit and skilled nursing facilities.

5 Mental health services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) using Blue Shield's MHSA participating providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the Evidence of Coverage or plan contract.

6 Optional substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "Substance Abuse Treatment Benefits."

7 Inpatient services for acute detoxification are covered under the medical benefit; see hospitalization services for benefit details. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield HMO providers.

8 Copayment does not apply when procedure is performed in conjunction with delivery or abdominal surgery.

9 Physician services copayment in the office or outpatient hospital facility only. If procedure is performed in a hospital facility setting, additional hospital services copayment may apply.

Plan designs may be modified to ensure compliance with state and federal requirements

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